Conclusions.– SAMSAH-Alister allows a multidimensional analysis of functioning in the middle of life. By proposing regular and coordinated care, then by overseeing relay implementation, it has found its positions in the care pathway as a multidisciplinary tool of interface participating in the achievement of the patients life plan [1].

Référence

[1] Yelnik AP, et al. Care pathways in PRM. Ann Phys Rehab Med 2011;54:463–4.

http://dx.doi.org/10.1016/j.rehab.2014.03.1496

CO92-004-e

Management of pressure sore at home, back from a survey about 2013 liberal nurses in Lille et Vilaine

S. Robineau-Beneux[a,*], A. Durufle[a], B. Nicolas[a], A. Chopin[a], M.P. Lebot[b], S. Petrilli[a], P. Gallien[a]
[a] *Pôle Saint-Helier, Rennes, France*
[b] *Centre Hospitalier Saint-Malo, France*
*Corresponding author.

Keywords: Pressure sore; Care at home; Training

Objective.– Understanding the epidemiology of pressure sores followed in town, doing an inventory of professional practices, assessing training needs.

Methods.– In total, 1173 questionnaires were sent by post to private nurses in private practice or home care services.

Results.– Two hundred and twelve responses (18%). Seventy-one percent have more than 10 years in private practice, 93% in group practice. Twenty-nine percent said they have taken care of pressure sores in the last year. Only 11% use an evaluation scale of risk. Eighty-nine percent use their right to prescription medical devices. Seventy-five percent feel that their formation is insufficient without distinction according their exercise seniority. In 80% of cases they consider the information at discharge of hospitalization as insufficient .Seventy-six percent say they are willing to participate in an evaluation of their practice. In 20% of cases caregivers are involved in pressure sore treatment. The organization of access to specialist advice is unclear.

Discussion.– This photography can give areas for improvement on training including pressure sore prevention coupling scales and clinical judgment and also the organization of access to expertise in Ille et Vilaine.

http://dx.doi.org/10.1016/j.rehab.2014.03.1497

CO92-005-e

Alternatives in the medical and social reception facilities: Innovative actions

J. Sengler[a,*], E. Lamon[b], N. Winisdoerffer[a]
[a] *Centre hospitalier de Mulhouse, Mulhouse*
[b] *Handicap Services, Alister*
*Corresponding author.

Objectives.– To present our alternative innovative experiences to the conventional medical and social reception facilities.

Methods.– A work in public-private network, the mobilization of private payers (social lessors, insurances, and foundations), the appeal to a specialized agency allowed the emergence of the plan.

Results.– Eight apartments for the big dependence and two family houses welcoming seventeen persons mainly "brain-damaged" are opened. A structure dedicated to the education for the autonomous life is in the course of finalization. A Brain-damaged Assistance service dedicated 24 hours over 24 hours 365 days a year accompanies the plan. The innovative principle of the mutualisation of the clearing service of the handicap (PCH) is the keystone of this functioning.

Discussion.– Will be discussed: the conditions of feasibility and success; the modalities of mutualisation of the PCH; the implementation of the service Cérébro Lésion Assistance; the work in network.

Conclusion.– These new devices allow the people in situation of severe handicap to live in open environment, in family for some, while protecting a social life. These original modalities are reproducible.

http://dx.doi.org/10.1016/j.rehab.2014.03.1498

CO92-006-e

For the return at home: Mobil teams brain-injury

M.M. Leclercq
Centre hospitalier de Mulhouse, Mulhouse

Keywords: Medico social follow-up; Link hospital home

Background.– Return at home of brain-injured patients is always a moment when all the helps and planned relays ought to be efficient. To ease this transition, medico social teams are organised in the Haut-Rhin and one of their mission is to insure the link between the sanitary and medico social field.

Objectives.– Presentation and description of functioning of the team.

Methods.– Analysis of the missions and annual reports.

Results.– Two multidisciplinary teams work to allow home stay in best conditions. Their integration in the rehab department insures better coordination. They can be solicited after acute medical or rehab department when people go home or decide to address patients back to hospital.

In 2012, 345 people where actively followed among which 33 benefit nowadays a back home supervision. The average duration of follow-up is 21.4 months.

Conclusion.– The support of caregivers and the existence of coordinated medical and medico social networks are essential to the home stay. These teams allow a reactive follow-up of difficult situations, while taking part in the personnel project of life.

http://dx.doi.org/10.1016/j.rehab.2014.03.1499